Witness Name: Carla Jones-Charles
Statement No.: First
Dated: 12 June 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF CARLA JONES-CHARLES

I, Carla Jones-Charles, will say as follows: -

1. I make this statement in response to a letter dated 17 May 2024 sent on behalf of the Chair of the UK Covid-19 Public Inquiry (the "Inquiry"), pursuant to Rule 9 of the Inquiry Rules 2006. This statement is made for the purposes of Module 3 of the Inquiry, which is examining the impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland. As requested, this statement focuses on the period of time between 1 March 2020 and 28 June 2022 (the "relevant period").

A. INTRODUCTION

2. I am a Director of Midwifery, working in that role in a hospital in the Midlands during the relevant period. A Director of Midwifery is the most senior midwife in an NHS Trust or Health Board, and is responsible for linking the strategic and operational objectives. In this position, I work closely with all staff in maternity services, supporting, mentoring and coaching them in the development and delivery of their roles. I am responsible for setting the strategic direction of maternity services supported by the chief nursing and working with the clinical director.

3. I remember news circulating about the first cases of Covid-19 in China, in January 2020, and then the first cases reported in the UK, but we had no information beyond that being reported in the news. Even in March 2020, there was a distinct lack of clarity over the nature and severity of the virus and the impact it might have on maternity services. The week before the first lockdown, I attended the Chief Midwifery Officer's

conference in Manchester, and even then we had no detailed information about what was about to happen or the implications of lockdown for maternity and other NHS services. When the first lockdown was announced in March 2020, there was then a call to arms by our Chief Executive Officer and our Chief Operating Officer, commencing daily tactical meetings where information was shared and discussed, ranging from how each service could manage cases, strategies for staffing short falls and what aspects of care we may need to forgo if staffing reached critical levels.

B. IMPACT OF THE PANDEMIC

4. The pandemic had a significant impact on our working conditions and practices, and on staff trying their best to ensure the provision of maternity services could continue. Midwives work long, hard hours at the best of times, and the pandemic exacerbated this. The initial guidance was that there was no need for masks except on the delivery suits, and this caused fear amongst a number of staff groups, with some refusing to work. Sonography staff refused to see patients without a mask and declined to have visitors in the room. We were also dealing with the changing information regarding vulnerable groups of staff and managing the effect of the loss of these groups on other staff.

5. During the first peak in April 2020, midwives were redeployed to intensive care to provide support as there were high volumes of patients requiring care, some of whom had been diagnosed with Covid-19. This obviously impacted those staff who were redeployed, but also those that remained, with many having to work longer and harder to cover. Staffing shortages were exacerbated by the policy of shielding, and also with staff needing to isolate for two weeks if they had contracted Covid-19 or been in contact with someone who had Covid-19. Additionally due to the inability to test quickly for the virus, more staff were off work as a precaution, for fear of transmission.

6. There were peaks and troughs in staff sickness, but there was a huge amount of goodwill, with managers working clinically to cover absences. Many people moved out of their homes, both to avoid passing on the virus to their loved ones but also to avoid contracting the virus from anyone in their household. My husband became very unwell with Covid-19, eventually spending 3 weeks in the Intensive Therapy Unit (ITU).

During the initial stages of his illness, I moved out of our house and into a hotel for a week. This was obviously a very difficult time for me, but I was by no means the only one to make such sacrifices. The lack of changing rooms was a real challenge for staff, the fear of going home wearing their uniforms and potentially transmitting Covid-19 to their families.

7. Testing was not always available, which made managing staffing issues more difficult than it needed to be. Furthermore, the lack of clarity and timely provision of guidance from above added to this, particularly around vulnerable staff or staff with vulnerable family members. Obtaining a list from NHS England as to what category of staff would be impacted by staff shielding measures was a real challenge. For example, people with diabetes were not initially part of this group. This lack of clarity also led to a degree of resentment from some staff towards managers, including me.

8. One of the most difficult aspects of the pandemic was around visitor restrictions. Again, there was no clear guidance initially, it was effectively left to individual services to decide the extent to which visitors were allowed. Staff were very afraid to have visitors in the clinical area. Our sonography team were the first to say they were not accepting visitors, followed by the antenatal clinic. Although many maternity services closed almost completely to visiting, as Head of Service, I took the decision to allow visitors in our delivery suites. This was a very difficult decision for me, as it meant many members of staff would feel, and potentially be, at risk. It was a case of balancing the needs of women with the needs and safety of our staff, and I thought it was a very important standard to maintain. We were one of the few hospitals in the region that continued to allow visitors to the labour and postnatal wards. That being said, we did not allow visitors in the triage department, as social distancing was not feasible due to the layout.

9. The use of virtual consultations did go some way to mitigating the impact of restrictions on the provision of maternity services. We moved to virtual consultations quite quickly. However, these were initially in the form of telephone calls as the technology was not sufficient. Furthermore, some staff members were concerned by the idea of patients not coming into the hospital for care – they were worried that issues might arise as those patients had not been seen face-to-face.

10. The impact on and sacrifice by staff cannot be understated. The physical and mental toll on colleagues was profound. Tragically, we had a member of staff who died from Covid-19 in April 2020, she was one of the first NHS staff to die. At least initially, there was little mental health support available for staff, just rudimentary elements with a staff psychologist only being made available after the summer of 2020. Given the scale of the pandemic and a stretched healthcare system struggling to respond, at least in the first few months, it was a case of 'just keep working'. Senior managers were not immune to this. People often underestimate the hours worked during the pandemic, but we were working at least 12 hours every single day, with no additional remuneration, just to ensure that staff were as safe as possible. National guidance was often published late on a Friday, meaning we would spend the weekend considering how to effectively implement that guidance in our services. It was an incredibly difficult time for everyone.

C. INFECTION PREVENTION AND CONTROL

11. There was not only a lack of Personal Protective Equipment (PPE), but a lack of national guidance as to when and where to wear it. We would count the number of boxes of masks and gloves, reporting on it weekly to the Clinical Commissioning Groups and the regional NHS England team. There was never enough stock, and what stock did exist was kept in a secure area, to ensure that it could be and not go missing, as there was significant hysteria about its availability. Only the labour wards had PPE to begin with and even then, there was a lack of capacity to train people on how to put on, wear and take off PPE correctly. The lack of FFP3 face masks was a significant issue, causing a palpable fear amongst staff. I had staff coming to me every day for reassurance that they would not contract the virus as a result of the lack of PPE, which I found extremely challenging. There were also challenges with fit testing capacity, although a significant effort was put into ensuring that staff were tested.

12. I am aware that PPE availability was an issue across the NHS. My Trust at the time made a decision to purchase PPE privately. Some of the stock provided by the government at the time had expired and we were being advised that we should still use them. There were instances of expiry dates having obviously being changed and

extended and being sent to Trusts for staff to use. I remember my husband, an emergency medicine doctor, coming home from work one day and ordering his own PPE online due to shortages at work. In fact, as I have already referred to, he became ill before he had a chance to use it.

13. When PPE was provided, we had significant issues with its suitability, particularly for people with beards. Protective hoods offered an alternative to standard PPE, providing a proper fit and protection to those members of staff. However, there was a distinct lack of access to hoods and, as a result, some people ended up trimming their beards. Those with beards for culturally reasons had significant challenges with this aspect and finding alternatives was challenging. Some ethnic minority staff reported feeling that they were more likely to be allocated patients with Covid-19 and these issues had to be reviewed.

D. VACCINATION ROLL-OUT

14. I found the vaccination roll-out difficult, both personally and professionally. There was some skepticism from ethnic minority people, including myself, towards the vaccine, due to a variety of factors. I did not take up the vaccine until January 2021, whereas my husband took it up straight away. The point is, it was a personal decision for people and each individual had their own reasons for wanting or not wanting to receive the vaccine. This made the proposed policy of vaccination as a condition of deployment a real challenge for me and my team.

15. Eight members of my team were threatened with termination of their contract for refusing the compulsory vaccination. I had to speak to these people and discuss the potential implications, as part of my role. This was an uncomfortable conversation both for staff and for those delivering the message. I am firmly of the view that staff should have been encouraged to take the vaccine, rather than forced or threatened, and, ultimately, it should have been left as a personal decision.

E. LONG-TERM IMPLICATIONS

16. During the pandemic we saw more retirements and fewer returners. A lot of people have moved to other services that offer home working. As a result, we have since had to work a lot harder to recruit and fill vacancies, rolling out a campaign of recruitment events. This continues to present a real challenge for the provision of services, as the workforce is even more stretched than it was as we entered the pandemic.

17. The residual impact on staff has been significant. Morale has remained low, with a feeling that the memory of Covid-19 has started to fade from the national consciousness but the personal impact is still there, just as strong. This has been exacerbated by extremely stringent key-performance indicators imposed from top-down, putting added pressure on staff. There is no real acknowledgement of the work and sacrifice involved in just keeping the NHS going – people are just expected to carry on. It is a testament to the strength of my colleagues, and the NHS workforce more generally, that we are still able to provide the services we do.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Carla Jones-Charles

Dated: **12 June 2024**